BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: **ERIKA M.,** **Claimant,** **vs.** **SOUTH CENTRAL LOS ANGELES REGIONAL CENTER,** **Service Agency.**	**OAH No. L 2006051083**

DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge with the Office of Administrative Hearings, on August 10, 2006, in Los Angeles, California. Erika M. (Claimant) was represented by Anastasia Bacigalupo with the Office of Clients' Rights Advocacy, who was Claimant's authorized representative.[1] Claimant's mother, Michelle P., also appeared on Claimant's behalf. South Central Los Angeles Regional Center (SCLARC or Service Agency) was represented by Julie A. Ocheltree of Enright & Ocheltree, L.L.P.

Oral and documentary evidence was received and argument was heard. The record was closed and the matter was submitted for decision on August 10, 2006.

ISSUE

Does the Claimant have a developmental disability entitling her to Regional Center services?

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[1] Claimant's and her family member's surnames are omitted, and initials are used instead, in order to protect their privacy.

FACTUAL FINDINGS

1a. Claimant is a 15-year-old female, born June 8, 1991. She claims to be eligible for regional center services on the basis of mild mental retardation or, in the alternative, on the basis of having a condition closely related to mental retardation or requiring treatment similar to that needed by people with mental retardation (commonly referred as the "fifth category"). The Service Agency takes the position that Claimant is not entitled to regional center services because her condition is solely a learning disability and not an eligible condition.

1b. On March 23, 2004, the Service Agency denied eligibility, and on December 8, 2005, Claimant's authorized representative requested that the Service Agency reassess her for eligibility. On April 26, 2006, the Service Agency again denied eligibility, and on May 25, 2006, Claimant requested a fair hearing.

2. Claimant was born premature, after pre-natal exposure to drugs. Claimant's adoptive mother is her maternal aunt, who has had custody of Claimant since 1992, when Claimant was an infant.

3a. On October 27, 2003, and January 17, 2006, Michael Gosano (Gosano), Intake Service Coordinator with SCLARC, conducted Social Assessments of Claimant, which both included an interview with Claimant's adoptive mother, Michelle P. At the interviews, Claimant's mother reported that Claimant met the following developmental milestones: Claimant sat up alone and finger-fed herself at six months old. She said her first words at 10 months old and began walking at 11 months old. She fed herself with a spoon at 12 months old, and was toilet trained at 18 months old.

3b. At the fair hearing, Michelle P. testified that Claimant walked at age two years old, was potty trained at two and one half years old and talked at three years old.

3c. The prior statements to Gosano regarding Claimant's developmental milestones mirrored the developmental milestones Michelle P. reported to Lisa M. Doi, Ph.D, during a psychological evaluation of Claimant on October 30, 2003. Michelle P.'s prior statements to Gosano and Dr. Doi were more credible than her testimony at the hearing, because they were made closer in time to the events described, and (to a lesser degree) because they were not made while contesting denial of Claimant's eligibility.

3d. Although the reporting of Claimant's early developmental milestones differed, the evidence did not establish that the milestones reported either at hearing, or to Gosano and Dr. Doi, were outside the range of normal development.

4a. Per Gosano's reports and Michelle P.'s testimony at the fair hearing, Claimant does not display any deficits in her motor skills. Claimant's self-help skills vary in level of ability. She is able to use a microwave oven, and she makes her bed and washes the dishes on a daily basis, without assistance. She eats neatly and independently. She takes care of her own hygiene and bathes without assistance. She also chooses her own clothing in the morning and can dress herself. However, she does not take medication on her own and does not use transportation without supervision. Although she is able to add coins up to $1.00 and can make some purchases in the community, she has difficulty calculating the change due to her, particularly with larger bills such as $20. Claimant cannot take a phone message, and she cannot tell time using an analog clock.

4b. Gosano noted that Claimant "appears to have good receptive and poor expressive skills."

4c. Claimant is able to form friendships and maintain them. She does not need coaxing to participate in social activities. She was a cheerleader at her junior high school.[2]

4d. Claimant currently has a summer job removing graffiti, where she is supervised by at least two adults. Since she could not read the employment application, her adoptive mother filled it out for her.

5. Claimant has had continued difficulty at school, which resulted in her receipt of special education services. She has completed junior high school and will attend high school in the fall.

6. On May 19, 1997, licensed clinical psychologist, Dr. Paul Wittenberg, conducted a psychological assessment of Claimant, who was then 5 years, 11 months old. He opined that Claimant was functioning within the Borderline Range of Intelligence.

7. On January 18, 1999, clinical psychologist Jaime Elizabeth Medvene, Ph.D., conducted psychological testing on Claimant who was then seven years old. Administration of the Wechsler Intelligence Scale for Children – Revised (WISC-R) yielded a Verbal IQ score of 68, a Performance IQ score of 80 and a Full Scale IQ score of 72, which was in the Borderline Range of Intellectual Functioning.

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[2] There was no evidence presented at hearing to indicate what criteria were used to select cheerleaders at Claimant's junior high school, or whether accommodations were made at try-outs for those students who received special education services.

8a. An Individualized Education Plan (IEP), dated May 28, 2003, when Claimant was 11 years, 11 months old noted:

> Student exhibits a significant, chronic underlying disorder in one or more of the basic psychological processes involved in understanding or in using languages, spoken or written, which is manifested in an impaired listen (sic), think, speak, read, write, spell or do mathematical calculations.

8b. The May 28, 2003 IEP later noted that Claimant was "functioning at an average level," without pointing to any testing or scores to substantiate this assertion.

9a. On September 20, 2003, upon the referral from the Department of Children and Family Services, licensed psychologist William H. Kroes, Ph.D., conducted a psychological assessment of Claimant at age 12 years, 3 months.

9b. Dr. Kroes noted that Claimant had reportedly been previously diagnosed with depression, with psychotic features. There was no indication from where this reported diagnosis had come.

9c. As part of his assessment, Dr. Kroes conducted several tests and made several findings, including:

(1) Claimant was administered Test of Non-verbal Intelligence – 3 (TONI-3), which yielded a standard score of 68. Dr. Kroes noted that Claimant's test score fell in the "intellectually deficient range of intelligence," and that she was functioning at the age equivalent of a 6 year old child. He further noted that Claimant's score "may be indicative of mental retardation, developmental disorders, or other cognitive disorders or significant behavioral problems."

(2) Claimant was administered the Vineland Adaptive Behavior Scales (Vineland), with her adoptive mother as the reporter. In the Communication Domain, Claimant obtained a standard score of 56, with an age equivalent of 7 years, 2 months. In the Daily Living Skills Domain, Claimant obtained a standard score of 58, with an age equivalent of 7 years, 2 months. In the Socialization Domain, Claimant obtained a standard score of 80, with an age equivalent of 8 years, 8 months. Claimant's Standard Score Composite was 56, which was "low." Dr. Kroes noted that, at the time of the evaluation, Claimant could not do the following: read books of at least second grade level; arrange items or words alphabetically by first letter; write short notes or messages; write in cursive most of the time; or use a dictionary.

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9d. Dr. Kroes observed:

> Intelligence testing indicates that [Claimant] is functioning in the Intellectually Deficient Range of Intellectual Ability. Adaptive functioning was also found to be significantly below average for her age level. The combination of significantly low intellectual and adaptive functioning warrants a diagnosis of Mild Mental Retardation.
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> [Claimant] is having trouble learning in school and a diagnosis of Learning Disorder NOS was also given.
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> Her caregiver reports that [Claimant] periodically becomes depressed. Behaviorally, however, there was no indication of depression during the assessment. For this reason a rule out diagnosis of a Depressive Disorder was given.

9e. Dr. Kroes diagnosed Claimant's condition as follows:

Axis I: [3] Learning Disorder, Not Otherwise Specified
R/O Dysthymic Disorder, Early Onset

Axis II: Mild Mental Retardation

Axis III: none observed or reported

Axis IV: Psychosocial and Environmental Problems:
Prenatal exposure to drugs
Separation from mother

10a. On October 30, 2003, licensed psychologist, Lisa M. Doi, Ph.D., conducted a psychological evaluation of Claimant.

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[3] The diagnoses are derived from the Diagnostic and Statistical Manual of Mental Disorders (4th edition, Text Revision 2000) (DSM-IV-TR), published by the American Psychiatric Association. The Administrative Law Judge takes official notice of the DSM-IV-TR as a highly respected and generally accepted tool for diagnosing mental and developmental disorders.

10b. As part of the evaluation, Dr. Doi administered the Wechsler Intelligence Scale for Children – Third Edition (WISC-III) to assess Claimant's cognitive functioning. The WISC-III yielded scores as follows:

Verbal IQ: 58 (mild deficit)
Performance IQ: 75 (borderline)
Full Scale IQ: 64 (mild deficit)

10c. In the area of adaptive functioning, Dr. Doi administered the Vineland; Claimant's adoptive mother provided the responses necessary for the completion of this test. In the Communication Domain, Claimant obtained a standard score of 51. In the Daily Living Skills Domain, Claimant obtained a standard score of 58. In the Socialization Domain, Claimant obtained a standard score of 80. Claimant's Adaptive Behavior Composite was 58. Dr. Doi found that Claimant's scores on the Vineland fell in the mild deficit range in communication and daily living skills and in the borderline range in socialization abilities.

10d. Dr. Doi diagnosed Claimant's condition as follows:

Axis I: Expressive Language Disorder

Axis II: Borderline Intellectual Functioning

Axis III: Prenatal substance exposure (by report)

11. On February 5, 2004, Dr. Doi administered Claimant the TONI-3. That test yielded a score of 99, which is within the range of average intelligence. Following that test, Dr. Doi amended Claimant's diagnosis as follows:

Axis I: Expressive Language Disorder
Learning Disorder Not Otherwise Specified

Axis II: No diagnosis

Axis III: Prenatal substance exposure (by report)

12a. A March 2005 Psychological Educational Assessment conducted by Claimant's school district when she was 14 years, 9 months old, and in seventh grade, noted that Claimant had been administered several tests, which included the following:

(1) A Comprehensive Test of Nonverbal Intelligence (CTONI) yielded a score of 77, which was below average.

(2) Woodcock Johnson III Tests of Cognitive Ability and Verbal Ability yielded a standard score of 79, which was below average, at an age equivalent of 8 to 11 years old, and at a grade equivalent 3.5. The March 2005 report noted that Claimant's "verbal cognitive ability appears to be less developed than her non-verbal ability."

(3) A Woodcock Johnson Test of Achievement revealed that Claimant's performance in mathematics, reading spelling and writing were all well below average, with age equivalents in the cluster tests ranging from 6 years, 10 months to 8 years, 8 months, and grade equivalents ranging from 1.3 to 3.1.

12b. In recommending special education services, the assessor noted that Claimant demonstrated "a very significant discrepancy between her ability and achievement in reading, mathematics and written expression that appears to be due primarily to weaknesses in auditory processing as well as possible expressive language delays."

13a. On June 14 and 16, 2005, licensed psychologist Christopher Ingalls, Ph.D., conducted a neuropsychological evaluation of Claimant, who was then 14 years old, and in seventh grade.

13b. As part of that evaluation, Dr. Ingalls administered the Wechsler Intelligence Scale for Children – IV (WISC IV), which yielded a full scale score of 56.

13c. In the area of adaptive functioning, Dr. Ingalls administered the Vineland. In the Communication Domain, Claimant obtained a standard score of 42. In the Daily Living Skills Domain, Claimant obtained a standard score of 64. In the Socialization Domain, Claimant obtained a standard score of 55. Claimant's Adaptive Behavior Composite was 52.

13d. Dr. Ingalls diagnosed Claimant's condition to include:

Axis I: No diagnosis

Axis II: Moderate mental retardation based on Full Scale IQ of 56 on the WISC-IV and Vineland Adaptive Behavior Scales Composite

Axis III: Probable prenatal drug exposures

Axis IV: Psychosocial stressors mild.

14a. On January 17, 2006, clinical psychologist Timothy D. Collister, Ph.D., conducted a psychological evaluation of Claimant who was then 14 years old. Dr. Collister reviewed the March 2005 psychological evaluation and the June 2005

report of Dr. Ingalls. In Dr. Collister's report, he opined that Dr. Ingalls mischaracterized the results of his testing by finding moderate mental retardation, when the scores obtained suggest mild retardation at worst. He further pointed out that "Dr. Ingalls does not provide a discussion to suggest why scores obtained by [Claimant's school district] would be much higher compared to what he obtained, nor why his results are significantly lower than what was previously obtained."

14b. Dr. Collister considered the results of his testing in conjunction with the results of Claimant's prior testing. According to Dr. Collister, "Verbal function, measured by the Peabody Picture Vocabulary Test [(Peabody)], show results at the upper end of the borderline range. A measure of nonverbal intellectual function, focusing on visualization and reasoning, is at the lower end of the borderline range (Leiter).

14c. Dr. Collister diagnosed Claimant's condition to include:

Axis I: Mixed Receptive-Expressive Language Disorder
Learning Disorders, Not Otherwise Specified

Axis II: No Diagnosis.

15. The February 5, 2004 TONI-3 score obtained by Dr. Doi was significantly and inexplicably higher than Claimant's other scores, including the other TONI testing. Additionally, Claimant's socialization domain score on the Vineland administered by Dr. Ingalls was inexplicably lower than Claimant's other socialization domain scores. However, the scores Claimant obtained using standardized, individually administered intelligence tests indicate a chronological decline in intellectual functioning from very low Borderline to mild mental retardation (WISC R in 1999 – full scale IQ 72; WISC III in 2003 – full scale IQ 64; WISC IV in 2005 - full scale IQ 56), and Claimant's Vineland scores generally indicate mild deficits in adaptive functioning, particularly in Communication and Daily Living Skills.

16a. At the fair hearing, Dr. Ingalls provided testimony on behalf of Claimant. He noted, under the DSM-IV-TR, one part of making a diagnosis of mental retardation involves evaluating intellectual functioning, with the Wechsler being the most common test, and the other part involves evaluating adaptive functioning, with the Vineland as the most common tool. He also noted that, built into every test is a standard range of error, so that a Performance IQ of 75 could fall within low average/borderline intellectual functioning to Mild Mental Retardation. He reiterated his opinion that Claimant meets the criteria under the DSM-IV-TR for Mild to Moderate Mental Retardation. He noted that Mild Mental Retardation may not be noticeable at first, but it gets more severe as time progresses. As an example, Dr. Ingalls pointed out that Claimant was still only at a second grade level academically.

16b. Dr. Ingalls' testimony was persuasive. Although Dr. Collister's report sought to refute Dr. Ingalls' determination that Claimant's full scale IQ of 56 could place her in the category of Moderate Mental Retardation, Dr. Collister's assertion was not convincing. The DSM-IV-TR specifies that Moderate Mental Retardation includes IQ levels between 35 to 55. However, as noted by Dr. Ingalls, the DSM-IV-TR states that "there is a measurement error of approximately 5 points in assessing IQ . . . (e.g. a Wechsler IQ of 70 is considered to represent a range of 65-75)." Therefore, Dr. Ingalls' determination that, considering the range of error, Claimant could fall into the range of Moderate Mental Retardation was within the parameters specified in the DSM-IV-TR.

17a. At the fair hearing, Dr. Collister provided testimony on behalf of the Service Agency and opined that Claimant does not have Mental Retardation. He pointed to the statement in the DSM-IV-TR which indicated that, "When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading." (DSM-IV-TR, p. 42.) Dr. Collister stated that, if a person's Verbal IQ is 58, her "non-verbal" score is 75, and her full scale IQ is 64, she does not necessarily have Mental Retardation; her one, isolated verbal score does not warrant that diagnosis. According to Dr. Collister, for Mild Mental Retardation to be diagnosed, a subtest IQ of 70 to 75 should be accompanied by deficits in adaptive functioning.

17b. Dr. Collister discounted Claimant's low scores in adaptive functioning, noting that adaptive functioning may be influenced by several factors, including mental health and emotional status. He also noted that the Vineland "is less objective." He maintained that, as indicated by the Peabody, the objective testing of Claimant's communication showed "higher" results.

17c. Dr. Collister stated that, if developmental milestones were within normal limits, one is less likely that have retardation later on, although he admitted it is possible. He maintained that, since Claimant's milestones passed within normal limits, this would weigh against a diagnosis of Mental Retardation. He also stated that Claimant's entire body of scores appears to be out of the retarded range and cumulatively weigh against a finding of Mental Retardation.

17d. Dr. Collister's testimony was not persuasive in the following regard:

(1) Dr. Collister's contention that the Vineland was "less objective" was not convincing enough to disregard Claimant's Vineland scores. There was no evidence that any information provided by Claimant's mother (to several separate evaluators) was inaccurate or that any of Claimant's skills were minimized. There was also no evidence that established that Claimant's adaptive functioning was affected by Claimant's mental health or emotional status.

(2) Dr. Collister discounted the notion that Claimant could have Mild Mental Retardation which did not present itself until later in her life. However, as noted in the DSM-IV-TR, persons with Mild Mental Retardation "typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age." (DSM-IV-TR, p. 43.)

LEGAL CONCLUSIONS

1. Claimant has established that she has a developmental disability entitling her to Regional Center services. (Factual Findings 2 through 17; Legal Conclusions 2 through 12.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. Where a claimant seeks to establish his/her eligibility for services, the burden is on the appealing claimant to demonstrate that the Service Agency's decision is incorrect. Claimant has met her burden of proof in this case.

3. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. Welfare and Institutions Code section 4512 defines "developmental disability" as:

> a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

4a. To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that he/she has a "substantial disability."

4b. California Code of Regulations, title 17, section 54001 states, in pertinent part:

> (a) "Substantial disability" means:
> (1) A condition which results in major impairment of cognitive and/or social functioning, representing

> sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and
> (2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:
> (A) Receptive and expressive language;
> (B) Learning;
> (C) Self-care;
> (D) Mobility;
> (E) Self-direction;
> (F) Capacity for independent living;
> (G) Economic self-sufficiency.

4c. In California Code of Regulations, title 17, section 54002, the term "cognitive" is defined as

> the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience.

5a. In addition to proving a "substantial disability," a claimant must show that his/her disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of eligibility is listed as "Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation." (Welf. & Inst. Code §4512.) This category is not further defined by statute or regulation.

5b. Whereas the first four categories of eligibility are very specific, the disabling conditions under this residual, fifth category are intentionally broad to encompass unspecified conditions and disorders. However, this broad language is not intended to be a catchall, requiring unlimited access for all persons with some form of learning or behavioral disability. There are many persons with sub-average functioning and impaired adaptive behavior; the Service Agency does not have a duty to serve all of them.

5c. While the Legislature did not define the fifth category, it did require that the qualifying condition be "closely related" (Welf. & Inst. Code §4512) or "similar" (Cal. Code. Regs., tit. 17, §54000) to mental retardation or "require treatment similar to that required for mentally retarded individuals." (Welf. & Inst. Code §4512.) The definitive characteristics of mental retardation include a significant

degree of cognitive and adaptive deficits. Thus, to be "closely related" or "similar" to mental retardation, there must be a manifestation of cognitive and/or adaptive deficits which render that individual's disability like that of a person with mental retardation. However, this does not require strict replication of all of the cognitive and adaptive criteria typically utilized when establishing eligibility due to mental retardation (e.g., reliance on I.Q. scores). If this were so, the fifth category would be redundant. Eligibility under this category requires an analysis of the quality of a claimant's cognitive and adaptive functioning and a determination of whether the effect on his/her performance renders him/her like a person with mental retardation. Furthermore, determining whether a claimant's condition "requires treatment similar to that required for mentally retarded individuals" is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. Many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training or living skills training). The criterion is not whether someone would benefit. Rather, it is whether someone's condition requires such treatment.

6. In order to maintain eligibility, a claimant's substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code §4512 and Cal. Code. Regs., tit. 17, §54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric disorders or solely learning disabilities. Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled with either a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate from just the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does not have a developmental disability, would not be eligible.

7. In this case, Claimant asserts that she suffers from either mild mental retardation or a condition similar to mild mental retardation. The Service Agency asserts that Claimant suffers from a learning disability which is the sole cause of any cognitive deficits. Claimant's assertion is supported by the weight of the evidence.

8a. The DSM-IV-TR describes mental retardation as follows:

> The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur

before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

Impairments in adaptive functioning, rather than a low IQ are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation

> are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

(DSM-IV-TR, pages 39 - 42.)

8b. The DSM-IV-TR states that persons with Mild Mental Retardation (I.Q. level of 50-55 to approximately 70):

> typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self- support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

(DSM-IV-TR, pages 42 - 43.)

9a. Claimant meets all three criteria under the DSM-IV-TR for a diagnosis of Mild Mental Retardation.

(1) She has demonstrated significantly subaverage general intellectual functioning (Criterion A). The scores Claimant obtained using standardized, individually administered intelligence tests indicate a continual decline in intellectual functioning, culminating in full scale IQ scores in the mild mental retardation range in 2003 (full scale IQ of 64) and 2005 (full scale IQ of 56). At least two DSM-IV diagnoses of Mental Retardation were made, and even the findings from Dr. Doi's testing supported those diagnoses. It is noted that, in Dr. Doi's 2003 evaluation, the one subtest score that created a "discrepancy" which warranted caution in averaging Claimant's subtest scores was a Performance IQ of 75, which indicated Borderline Intellectual Functioning, as compared to a Verbal IQ of 58. The Performance IQ of 75 was within the five-point margin of error, and therefore was not so high that Mild Mental Retardation must be ruled out.

(2) Furthermore, the concern about averaging of subtest scores was addressed by Claimant's significant deficits in adaptive functioning in the areas of communication, self-care, home living, self-direction and functional academic skills. (Criterion B.) Claimant's Vineland scores generally indicate deficits in adaptive

functioning, particularly in the Communication and Daily Living Skills (self-care, home living, and self-direction) Domains. There was no dispute that Claimant suffers from expressive language problems. Additionally, at age 15, she cannot tell time, take medicine independently, take a phone message, fill out an employment application, use public transportation or calculate change from a $20 bill.

(3) Since the onset of Claimant's deficits in intellectual and adaptive functioning occurred prior to age 18, she meets the Criterion C under the DSM-IV-TR. There was no evidence of any requirement that Claimant must be diagnosed in infancy or even prior to her current age. Instead, as indicated by the DSM-IV-TR, Mild Mental Retardation is "generally noticed later," and those with Mild Mental Retardation "are not distinguishable from children without Mental Retardation until a later age." (DSM-IV-TR, pp. 43 and 47.)

10. Based upon the evidence presented, Claimant has met her burden of proof regarding her assertion that she suffers from Mild Mental Retardation.[4]

11. Based upon the evidence presented, Claimant has also met her burden of proof that she has a substantial disability as defined by Welfare and Institutions Code section 4512, and California Code of Regulations, title 17, section 54001. Claimant suffers from a major impairment of cognitive functioning, as well as significant functional limitations in expressive language, learning, self-care and self-direction.

12. The weight of the evidence supports a finding that Claimant is eligible to receive regional center services.

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[4] Given the finding of Mild Mental Retardation, Claimant's assertion regarding fifth category eligibility will not be addressed.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Claimant's appeal of the Service Agency's determination that she is not eligible for regional center services is sustained. The Service Agency shall accept Claimant as a consumer forthwith.

DATED: August 21, 2006

JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.